CHAPTER 10

MEDICAID STATE PLAN SERVICES

CHILDREN'S PERSONAL CARE
INCONTINENCE SUPPLIES (UNDER 21)

Children's Personal Care Aide (CPCA) Services

Children's Personal Care Aide Services (CPCA) are available to Medicaid eligible children under age 21 who meet established medical necessity criteria. To qualify for CPCA services a child must meet the Service Needs Requirement and, unless otherwise specified, have one of the Functional deficits listed below:

Functional Deficits*

1. Requires extensive (hands on) assistance with bathing **and** dressing **and** toileting **and** feeding if otherwise age appropriate** functioning would normally allow these activities. (All four must be present and constitute one deficit).

2. Requires extensive (hands on) assistance with walking or wheelchair locomotion if these are otherwise age appropriate activities**.

3. Requires extensive (hands on) assistance with transfer if otherwise age appropriate activity**.

4. Requires extensive (hands on) assistance with daily incontinence care (if continence is otherwise age appropriate**) or with daily catheter or ostomy care.

***** For infants ages 0-1, functional deficits generally will not apply. Medical necessity is based on Service Needs Requirement only.

** For children 0-5 years of age, Attachment A-"Guide to Developmental Stages of Children" may be used to determine age-appropriate activity.

Note: To receive CPCA services, a child must meet the Service Needs Requirements and have at least one (1) Functional Deficit.

Children's Personal Care services are not intended to supplant care provided by the parents/family or other natural/legal caregivers.

Service Needs Requirement

A physician must certify that the child requires daily monitoring and observation due to medical needs which could result in complications and that the services of a Personal Care Aide are required and intended to maintain the child's optimum health status.

CPCA Services are designed to help with normal daily activities and to monitor the medical conditions of the child. Aides providing this service may assist with ambulation/walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. In addition to the hands-on care provided to the child, aides may also help to maintain the child's home environment by performing light cleaning, laundry for the child, and tasks to keep the home safe for the child but these tasks may not be performed as discrete activities.

Aides work under the supervision of an RN or LPN but may not perform any type of skilled medical services. Aides may observe the child's vital signs such as respiratory rate, pulse rate, and temperature.

During the provision of the CPCA services, aides must be actively engaged in the completion of allowable tasks determined by the Service Coordinator to be needed. The provision of this service does not include supervision

of the child ("childcare") as a discrete task nor does it include down-time between tasks or time waiting for a task to be needed.

A personal care aide is not allowed to render services in a school setting or during homebound instruction. CPCA must be provided in the recipient's home.

The unit of service is 15 minutes of service provided by one PCA.

Please see: Scope of Services for Personal Care 2 (PC II) Services

Providers: CPCA Services must be provided to children by an agency enrolled with the Department of Health and Human Services.

Arranging for and authorizing the service: When a child is believed to have needs that can be met through the provision of CPCA Services, access to those services may be obtained in one of two ways:

1. For children who are NOT ENROLLED in the Department of Disabilities and Special Needs' (DDSN) Intellectual Disability/Related Disabilities (ID/RD) Waiver or Community Supports (CS) Waiver, access to CPCA is gained by referring the child to the Community Long Term Care (CLTC) area office in the child's area. If a physician determines a child qualifies for CPCA service, CLTC area office staff will conduct the assessment of need and authorization for service.

2. For children who are ENROLLED in either the ID/RD Waiver or CS Waiver, if a physician determines the child qualifies for CPCA services, the assessment of need and authorization of services is made by the child's Service Coordination/Early Intervention. The Service Coordinator will obtain a physician's order using the attached MSP Form 1. The Service Coordinator will also complete the CPCA Screening (attached MSP Form 2) and the CPCA Request Form (MSP Form 2-A).

Service Approval: At the time of annual planning, all children enrolled in the ID/RD or CS Waiver **must have a newly completed physician's order, CPCA Screening, CPCA Request, and authorization** (see MSP forms/attachments). For children meeting both the "Service Needs Requirement" and who have a "Functional Deficit", service coordinators may authorize up to 10 hours (40 units) per week without additional prior approval. If the request indicates a need for services in excess of 10 hours (40 units) per week, prior authorization from DDSN Central Office must be obtained and must be reviewed each year at the time of planning. Requests must:

- specifically explain need/reason for the amount of service
- include the completed screening and request forms
- include the proposed schedule for service delivery
- include supporting medical documentation
- be submitted to: Michelle Abney (see contact information below)

NOTE: Under no circumstances shall any amount more than 10 hours (40 units) per week be authorized without prior approval from DDSN. Send requests to:

SCDDSN
Attn: Michelle Abney
PO Box 4706
Columbia, SC 29240

Or Fax/Email : (803) 898-9660
MAbney@ddsn.sc.gov

Written documentation supporting this approval must remain in the participant record.

CPCA Services should not be included in the Waiver budget.

NOTE: If the completed physician's order or CPCA screening or CPCA request indicates that either no service is needed or a reduced amount of service is needed, the Service Coordinator must issue a Notice of Termination/Reduction or Suspension at least ten (10) working days prior to the actual termination/reduction of the service. The reconsideration/appeals process must be attached.

Once the Service Coordinator has assessed the amount of services needed, obtained a Physician's order, and, if applicable, obtained approval from DDSN, the parents/guardian should be given a listing of available Personal Care providers from which to choose. This offering of provider choice must be documented. Once the service is approved and a Personal Care provider is selected, the Service Coordinator should complete the Authorization for CPCA Services (MSP Form 3) and send a copy to the chosen agency. This authorization remains in effect until a new/revised Authorization for CPCA Services is sent or until services are terminated. **The physician's order must be attached to the authorization**.

Monitoring Services: Because CPCA is not a waiver service, the Service Coordinator need only monitor CPCA as part of routine "Plan Review"**.**

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the parent/guardian including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the parent/guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. The attached MSP Form 4 will be used to reduce, suspend or terminate the service when applicable.

NOTE: When a child turns 21 years old, CPCA Services can no longer be received as a State Plan Medicaid Service. Please refer to the Enrollments Chapter/information from the appropriate Waiver manual for instruction on how to transition a child from CPCA services to waiver funded Personal Care Services.

If a child who is receiving CPCA Services is disenrolled from the ID/RD or Community Supports Waiver and will continue to need CPCA services, a referral must be made immediately to the CLTC office in the child's county area. Contact the DDSN Central Office Waiver Coordinator if assistance is needed for transition.

Guide to Developmental Stages of Children

1 month
- Makes crawling movements when prone
- When held in standing position, body limp at knees and hips
- In sitting position back is uniformly rounded, absence of head control

2 months
- Turns from side to back
- When prone, can lift head almost 45 degrees off table
- When held in sitting position, holds head up but head bobs forward

3 months
- Holds head high, makes crawling movements when prone
- Able to hold head more erect when sitting, but still bobs forward
- When held in standing position, able to bear slight fraction of weight on legs
- Supports weight on forearms
- Able to raise head and shoulders from prone position to 45-90 degree angle from table
- Opens hand spontaneously

4 months
- Rolls from back to side
- Able to sit erect if propped up
- Supports weight on feet briefly with underarm support

6 months
- When held in standing position, bears almost all of weight
- Sits with support
- Lifts legs high, holds them out straight

7 months
- Bears full weight on feet
- Rolls over easily
- Sits without support
- Pushes up on hands and knees and rocks

8 months
- Readily bears weight on legs when supported, may stand holding onto furniture
- Crawls on belly – arms used to pull body forward

9 months
- Crawls, may progress backward at first
- Sits steadily on floor for prolonged time (10 minutes)
- Pulls self to standing position and stands holding onto furniture
- Makes stepping movements

10 months
- Pulls self up
- Can hold bottle and feed self crackers
- Can drink from cup
- Crawls by pulling self forward with hands
- Pulls self to sitting position
- Stands while holding onto furniture, sits by falling down

12 months
- Begins to stand alone and toddle
- Uses spoon
- Cruises or walks holding onto furniture or with hand held
- May attempt to stand alone momentarily

- Can sit down from standing position without help

15 months
- Walks without help (usually since age 13 months)
- Creeps up stairs
- Assumes standing position without support
- Uses cup well
- Feeds self with regular cup with little spilling

18 months
- Runs clumsily, falls often
- Walks upstairs with one hand held
- Seats self on chair
- Manages spoon, but some spilling
- Takes off gloves, socks, and shoes and unzips

24 months
- Walks up and down stairs, has steady gait
- Holds cup for drinking
- Feeds self with spoon
- Cooperates with toilet training
- Runs fairly well, with wide stance
- Dresses self in simple clothing
- Participates in bathing

3 years
- Undresses self, washes and dries hands
- Feeds self with spoon
- May attend to toilet needs without help except for wiping
- Buttons and unbuttons accessible buttons
- Pulls on shoes
- Should have achieved daytime bowel and bladder control with occasional accidents

4 years
- Buttons front and side of clothes
- Bathes self with directions

5 years
- Has good motor control
- Washes self
- Cares for self totally, occasionally needing supervision in dress or hygiene
- Should have achieved daytime and nighttime bowel and bladder control

Revised 10/7/09

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CHILDREN'S PERSONAL CARE AIDE (PCA)
PHYSICIAN INFORMATION FORM

CHILD'S NAME: _____

SECTION I – MEDICAL INFORMATION

DATE OF LAST OFFICE VISIT: _____

DIAGNOSIS: _____
_____

CURRENT PHYSICAL CONDITION AND LIMITATIONS: _____
_____
_____

CURRENT MEDICATIONS AND TREATMENT PLAN: _____
_____

SECTION II – THE INFORMATION IN THIS SECTION IS REQUIRED IN ORDER TO DETERMINE IF THE CHILD QUALIFIES FOR THIS SERVICE.

SERVICE NEED: (CIRCLE ONE)

YES NO THE INDIVIDUAL REQUIRES DAILY MONITORING AND OBSERVATION DUE TO MEDICAL NEEDS WHICH COULD RESULT IN MEDICAL COMPLICATIONS. THE MEDICAL NEEDS ARE DOCUMENTED, AND THE SERVICES OF A PERSONAL CARE AIDE ARE REQUIRED AND INTENDED TO MAINTAIN OPTIMUM HEALTH STATUS. **(NOTE: A PERSONAL CARE AIDE CANNOT PERFORM ANY SKILLED TASKS)**

PLEASE SPECIFY:

_____
_____
_____

HOW LONG WOULD YOU EXPECT PCA SERVICES TO BE NEEDED?
☐ 3 MONTHS ☐ 6 MONTHS ☐ 9 MONTHS ☐ 12 MONTHS ☐ INDEFINITE

PLEASE CONTINUE ON REVERSE SIDE OR NEXT PAGE

SECTION III

PLEASE CHECK BELOW ALL SPECIFIC CARE NEEDS NECESSARY FOR THIS CHILD AND INDICATE THE FREQUENCY:

	SPECIAL CARE OR TREATMENT	FREQUENCY		DIETARY	FREQUENCY
	MONITOR MEDICATIONS			TUBE FEEDING	
	CATHETER/OSTOMY			SPECIAL DIET	
	VITAL SIGNS			TYPE:	
	SAFETY		COMMENTS:		
	VENTILATOR				
	TRACHEOSTOMY				
	SUCTIONING				
	OTHER (SPECIFY)				

_____ _____

PHYSICIAN SIGNATURE DATE

PHYSICIAN NAME: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CHILDRENS PERSONAL CARE AIDE ASSESSMENT

WAIVER PARTICIPANT'S NAME: _____DOB/AGE: _____/_____

I. PLEASE LIST ALL MEDICAL CONDITIONS AND WHEN EACH CONDITION FIRST OCCURRED. USE AN EXTRA SHEET OF PAPER IF YOU NEED MORE SPACE.

DIAGNOSIS/MEDICAL CONDITION		DATE FIRST OCCURRED
1.		
2.		
3.		
4.		

II. LIST ALL PERSONS INCLUDING PAID SERVICE PROVIDERS (E.G., NURSES, RESPITE CARE, ETC) WHO ARE NOW HELPING CARE FOR THE CHILD. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

PERSON/RELATIONSHIP	**TIMES** EACH DAY & **DAYS** EACH WEEK WHEN HELPING

III. PROVIDE A TWO WEEK SCHEDULE THAT SHOWS HOW/WHEN SERVICES/SUPPORTS (INCLUDING NATURAL SUPPORTS) ARE PROVIDED. INCLUDE THE ANTICIPATED SCHEDULE FOR PERSONAL CARE. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

ASSISTANCE NEEDED	ASSISTANCE REQUIRED	FREQUENCY, TIME REQUIRED, TIMES PER WEEK

A. **PERSONAL CARE**

BATH: BED ☐ SHOWER/TUB ☐ EXTENSIVE☐ PARTIAL☐ NONE☐; ___ X DAILY, 30 MIN ☐ OTHER __, __X WEEKLY

ORAL HYGIENE: EXTENSIVE ☐ PARTIAL☐ NONE☐; ___ X DAILY, 10 MIN ☐ OTHER __, __X WEEKLY

SKIN CARE: EXTENSIVE ☐ PARTIAL☐ NONE☐; ___ X DAILY, 10 MIN ☐ OTHER __, __X WEEKLY

DRESSING AND GROOMING: EXTENSIVE ☐ PARTIAL☐ NONE☐; ___ X DAILY, 15 MIN ☐ OTHER __, __X WEEKLY

SHAVING(AGE APPROPRIATE -14 OR OVER):☐ N/A EXTENSIVE ☐ PARTIAL☐ NONE☐; ___ X DAILY,15 MIN ☐ OTHER __, __X WEEKLY

INCONTINENCE CARE: (FOR CHILDREN AGE 4 & UP): EXTENSIVE ☐ PARTIAL☐ NONE☐; ___ X DAILY, 30 MIN ☐ OTHER __, __X WEEKLY

TOILETING: EXTENSIVE ☐ PARTIAL☐ NONE☐; ___ X DAILY, 15 MIN ☐ OTHER __, __X WEEKLY

RE-POSITIONING/TURNING IN BED: EXTENSIVE ☐ PARTIAL☐ NONE☐; ___ X DAILY, 10 MIN ☐ OTHER __, __X WEEKLY

MONITORING MEDICATION: EXTENSIVE ☐ PARTIAL☐ NONE☐; ___ X DAILY, 10 MIN ☐ OTHER __, __X WEEKLY

(E.G., INFORMING THAT IT IS TIME TO TAKE MEDICATION AS PRESCRIBED OR AS INDICATED ON THE LABEL OR HANDING A MEDICATION CONTAINER – THE AIDE IS NOT RESPONSIBLE FOR GIVING MEDICATIONS).

MEDICAL MONITORING OF CONDITION – SPECIFY :
(E.G., MONITOR TEMPERATURE, CHECK PULSE RATE, OBSERVE RESPIRATORY RATE OR CHECK BLOOD PRESSURE).

_____ EXTENSIVE ☐ PARTIAL☐ NONE☐ FREQUENCY, TIME REQUIRED ___, ___X WEEKLY

_____ EXTENSIVE ☐ PARTIAL☐ NONE☐ FREQUENCY, TIME REQUIRED ___, ___X WEEKLY

EXERCISE: EXTENSIVE ☐ PARTIAL☐ NONE☐ FREQUENCY, TIME REQUIRED ___, ___X WEEKLY

TRANSFERS:

MANUAL ☐ EXTENSIVE ☐ PARTIAL☐ NONE☐ ___X DAILY, 10 MIN ☐ OTHER ___, __ X WEEKLY

HOYER ☐ EXTENSIVE ☐ PARTIAL☐ NONE☐ ___X DAILY, 10 MIN ☐ OTHER ___, __ X WEEKLY

SLIDING BOARD ☐ EXTENSIVE ☐ PARTIAL☐ NONE☐ ___X DAILY, 10 MIN ☐ OTHER ___, __X WEEKLY

LIFT SYSTEM ☐ EXTENSIVE ☐ PARTIAL☐ NONE☐ ___ X DAILY, 10 MIN ☐ OTHER ___, __ X WEEKLY

WALKING: ☐ N/A – CAN'T WALK EXTENSIVE ☐ PARTIAL☐ NONE☐ ___ X DAILY, 10 MIN ☐ OTHER ___, __ X WEEKLY

WHEELCHAIR LOCOMOTION EXTENSIVE ☐ PARTIAL☐ NONE☐ ___ X DAILY, 10 MIN ☐ OTHER ___, __X WEEKLY

OTHER: _____ EXTENSIVE ☐ PARTIAL ☐ NONE☐ ___ X DAILY, 30 MIN ☐ OTHER ___, __X WEEKLY

OTHER PERSONAL CARE NEEDS:

_____ EXTENSIVE ☐ PARTIAL ☐ NONE☐ ___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY

_____ EXTENSIVE ☐ PARTIAL ☐ NONE☐___ X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY

ASSISTANCE/TIME NEEDED FOR PERSONAL CARE (TOTAL SECTION A) : _____

B. **MEAL AND DINING**

PREPARATION AND SET-UP: EXTENSIVE ☐ PARTIAL☐ NONE ☐___ X DAILY, 30 MIN ☐ OTHER __, __X WEEKLY

DINING/FEEDING: EXTENSIVE☐ PARTIAL☐ NONE ☐___ X DAILY, 30 MIN ☐ OTHER __, __X WEEKLY

CLEAN UP: EXTENSIVE☐ PARTIAL☐ NONE ☐___ X DAILY, 30 MIN ☐ OTHER __, __X WEEKLY

ASSISTANCE/TIME NEEDED FOR MEALS/DINING (TOTAL SECTION B): _____

GENERAL/HOUSEHOLD

FLOOR CLEANING PARTICIPANT'S ROOM/AREA: ___ X WEEKLY, 15 MIN ☐ OTHER ___

DUSTING PARTICIPANT'S ROOM/AREA: ___ X WEEKLY, 15 MIN ☐ OTHER ___

STRAIGHTENING PARTICIPANT'S ROOM/AREA: ___ X WEEKLY, 30 MIN ☐ OTHER ___

CHANGING BED LINENS: ___ X WEEKLY, 15 MIN ☐ OTHER ___

PARTICIPANT'S LAUNDRY: ___ X WEEKLY, 90 MIN ☐ OTHER ___

ASSISTANCE/TIME NEEDED GENERAL/HOUSEHOLD (TOTAL SECTION C): _____

TOTAL ASSISTANCE/TIME NEEDED IN ALL AREAS: _____

NOTES:

_____ _____

SIGNATURE OF PERSON COMPLETING/TITLE **DATE**

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Medicaid State Plan Services for Children in a HCB Waiver

AUTHORIZATION FOR CHILDREN'S PERSONAL CARE SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

You are hereby authorized to provide ☐ **Personal Care II (T1019)** ***for:***

Participant's Name: _____ **Date of Birth:** _____ **(must not be 21 or older)**

Address: _____
_____
_____

Phone Number: _____ **Medicaid #:** _____ **Social Security #:** _____

Only the number of units rendered maybe billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Start Date: _____

Authorized Total – Children's PCA ___ Units per week (1 unit = 15 minutes)

Service Tasks Requested:

☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
☐ Assistance with meals such as feeding, preparing/cooking meals, post-meal cleanup, etc.
☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
☐ Assistance with exercise, locomotion, positioning, etc.

Please note: Physician's order is attached.

Service Coordination Provider: _____ Service Coordinator Name: _____
Address: _____
_____
_____

Phone #: _____

_____ _____
Signature of Person Authorizing Services Date

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
NOTICE OF TERMINATION, REDUCTION, DENIAL OR SUSPENSION OF MEDICAID STATE PLAN SERVICE

TO: _____
LEGAL GUARDIAN/PARENT OF WAIVER PARTICIPANT

_____

_____

AND

_____
SERVICE PROVIDER AGENCY/COMPANY

_____

_____

RE: _____ _____
CHILD'S NAME DATE OF BIRTH

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
MEDICAID ID NUMBER

EFFECTIVE _____, THE FOLLOWING **MEDICAID STATE PLAN** SERVICE:
DATE

- ☐ **CHILDREN'S** PERSONAL CARE
- ☐ **CHILDREN'S** STATE PLAN NURSING

IS BEING: ☐TERMINATED: _____
☐ REDUCED: A NEW AUTHORIZATION WITH ADJUSTED UNITS WILL BE ISSUED
☐ SUSPENDED: AUTHORIZATION WILL BE ISSUED WHEN SERVICES CAN BEGIN
☐DENIED: _____

ONLY UNITS OF SERVICE RENDERED PRIOR TO OR ON THE EFFECTIVE DATE NOTED ABOVE MAY BE BILLED.

_____ _____
SIGNATURE OF SERVICE COORDINATOR PRINT NAME

DATE OF ISSUE/SIGNED:_____

SC CONTACT INFORMATION: _____
AGENCY

_____
PHONE NUMBER

MSP FORM 4
3/201

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS
for
MEDICAID STATE PLAN SERVICES

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for authorizing some Medicaid State Plan services for Intellectual Disability/Related Disabilities (ID/RD) Waiver, Community Supports (CS) Waiver and Head and Spinal Cord Injury (HASCI) Waiver participants. A request for reconsideration of an adverse decision **must be** sent in writing to:

SC Department of Disabilities and Special Needs
Attn: State Director
P. O. Box 4706
Columbia, SC 29240

The SCDDSN reconsideration process **must be** completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for benefits/services to continue during the reconsideration/appeal process, the participant /representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the participant/representative may be required to repay benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the participant/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the participant/representative fully completes the above reconsideration process and is dissatisfied with the results, the participant/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The participant/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The participant/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the participant/representative must clearly state with specificity, which issue(s) the participant/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The participant/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

Medicaid State Plan
Incontinence Supplies (Under 21)

Incontinence Supplies are available to Medicaid eligible children under age 21 who meet established medical necessity criteria.

Providers: Incontinence supplies must be provided by licensed vendors enrolled with SCDHHS as Incontinence Supply provider.

Covered Supplies: Medicaid State Plan offers the following incontinence supplies based on medical necessity:

- One (1) case of diapers or briefs [1 case = 96 diapers or 80 briefs]
- One (1) case of incontinence pads/liners [1 case = 130 pads]
- One (1) case of underpads
- One (1) box of wipes
- One (1) box of gloves

Note: Requests for additional supplies will be considered on a case by case basis **and** if medical necessity is justified.

Criteria: The following criteria must be met for children to receive incontinence supplies:

1. The child must be between ages 4 - 20.
2. The child's inability to control bowel or bladder function must be must be confirmed by a Physician on the **Physician Certification of Incontinence (DHHS Form 168IS**).
3. The Service Coordinator must conduct an assessment to determine the frequency and amount of supplies authorized.

Arranging for the Service: Once the child's need has been identified and documented in the plan and in the participant record, you must determine if the individual is eligible for incontinence supplies by having a physician complete the **Physician Certification of Incontinence (DHHS Form 168IS).** This form must be completed annually. Upon completion of the physician certification, you must conduct a telephone assessment to determine the frequency of incontinence and the amount of supplies to be authorized. The frequency definitions are as follows:

Occasionally Incontinent =

- Bladder—Not daily. Approximately 2 or less times a week
- Bowel—Approximately once a week

Frequently Incontinent =

- Bladder—Approximately between 3 to 6 times a week, but has some control OR if the client is being toileted (w/extensive assistance) on a regular schedule.
- Bowel—Approximately between 2 to 3 times a week.

Totally Incontinent =

- No control of bladder or bowel

NOTE: If the child has an ostomy or catheter for urinary control <u>and</u> an ostomy for bowel control, <u>only</u> underpads may be authorized.

NOTE: If the child has an appliance for bowel <u>or</u> bladder control, diapers may be authorized based on the frequency of incontinence.

When conducting the assessment, you should determine the number of diapers used on average per day to calculate the number of cases of diapers and other supplies needed per month. This should be thoroughly recorded in service notes to justify the need.

Once a frequency and amount has been determined, the individual must make a choice of provider and you must complete an **Authorization for Incontinence Supplies (Form IS-3)** and send it to the provider. A copy of the authorization must remain in the individual's file. FOR INDIVIDUAL'S UNDER AGE 21, DO NOT ADD INCONTINENCE SUPPLIES TO THE BUDGET.

<u>Note:</u> An authorization for wipes is based on the presence of an incontinence need only; therefore, an individual **must also be receiving** diapers and/or underpads in order to receive wipes. Wipes cannot be authorized for cosmetic or other general hygiene purposes. They can only be authorized for the participant's incontinence care.

<u>Monitoring Services:</u> Because Incontinence Supplies for children is not a waiver service, you need only monitor as part of the routine "Plan Review"**.**

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS
for
MEDICAID STATE PLAN SERVICES

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for authorizing some Medicaid State Plan services for Intellectual Disability/Related Disabilities (ID/RD) Waiver, Community Supports (CS) Waiver and Head and Spinal Cord Injury (HASCI) Waiver participants and the Pervasive Development Disorder (PDD) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to:

SC Department of Disabilities and Special Needs
Attn: State Director
P. O. Box 4706
Columbia, SC 29240

The SCDDSN reconsideration process must be completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the participant/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the participant/representative fully completes the above reconsideration process and is dissatisfied with the results, the participant/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The participant/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

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Columbia, SC 29202-8206

The participant/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the participant/representative must clearly state with specificity, which issue(s) the participant/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The participant/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

AUTHORIZATION FOR SERVICES

SC MEDICAID STATE PLAN INCONTINENCE SUPPLIES

TO: _____

_____

RE: _____

Individual's Name **Date of Birth**

_____

Address **Phone #**

Medicaid # ____/____/____/____/____/____/____/____/____/____/

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing the Community Supports Waiver. Our information indicates this person has:

☐ Medicaid ☐ 3rd Party liability (private insurance) ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # C S ____/____/____/____/____/

_____ **Diapers**/each **Start Date:** _____

Size: ☐ Adult Small (T4521) ☐ Adult Medium (T4522) ☐ Adult Large (T4523)
☐ Adult X-Large (T4524) ☐ Adult Bariatric (T4543)
☐ Child Small/Medium (T4529) ☐ Child Large (T4530) ☐ Youth (T4533)

Number of Diapers:_____ Per ☐**Month**

_____ **Briefs**/each **Start Date:** _____

☐ Adult Brief /Ex. Lrg (T4528) ☐ Adult Brief / Lrg (T4527) ☐ Adult Brief /Med. (T4526)
☐ Adult Brief /Sm. (T4525) ☐ Youth Brief (T4534) ☐ Child Brief Small (T4531)
☐ Child Brief Large (T4532)

Number of Briefs:_____ Per ☐**Month**

_____ **Incontinence Pads (Liners)**/each (T4535) **Start Date:** _____

Number of Pads:_____ Per ☐**Month**

_____ **Underpads**/case (A4554) **Start Date:** _____

Number of Cases:_____ Per ☐**Month**

_____ **Wipes**/box (T5999) **Start Date:** _____

Number of boxes:_____ Per ☐**Month**

_____**Gloves**/1box (A4927) **Start Date:**_____

Service Coordinator/Early Interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____ _____

Signature of Person Authorizing Services Date

COMMUNITY SUPPORTS Form IS-3